DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/26/11

PRINTED: 05/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED REGIONAL MEDICAL CENTER NURSING HOME	1001 MCARTHUR DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	F159 This facility does, upon written authorization of a resident, hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. On 5/11/2011, all residents having money in the resident trust account, from 1/1/2011 through 3/31/2011, had interest allocated as of 3/31/2011 by the Business Office Manager. Any resident having money in the resident trust account will have the potential to be affected. The Business Office Manager or her designee will be responsible for ensuring the interest is accrued quarterly. This will be done by monitoring the bank statement and allocating interest accrued accordingly. Quarterly audits will occur by the Business Office Manager or her designee to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the Business Office Manager. The QA Committee will make recommendations and develop an action plan if areas of	6/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Beth Hopkins — TITLE: Administrator — (X6) DATE: 5/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of resident trust fund accounts the facility failed to ensure the accounts were credited with interest for twenty-four of twenty-four trust fund accounts reviewed. The findings included: Review of the trust fund accounts revealed twenty-four residents had trust funds in a pooled account in January and February 2011, with a total balance of $5,999.64 on February 28, 2011. Review of the Trust Fund Trial Balance dated December 1, 2010, through March 31, 2011, revealed interest was applied to the accounts on December 31, 2010, however, no interest was applied to the accounts in March 2011. Interview on May 10, 2011, at 2:30 p.m., with the Business Office Manager (BOM), in the Director of Nursing's office, revealed the facility had a change of ownership in March 2011, and the resident trust fund account was closed, and reopened into a different account. Continued interview with the BOM revealed interest accrued for March 2011 would be applied to the resident trust accounts in July 2011. Continued interview	F 159	noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	

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F 159	Continued From page 2 confirmed the twenty-four residents with trust accounts in January and February did not receive credit for earned interest at the end of the quarter.	F 159		
F 161 SS=F	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the surety bond, review of bank statements, and interview, the facility failed to ensure the surety bond was sufficient to ensure the resident trust accounts. The findings included: Review of the facility's surety bond revealed the surety bond was issued on March 1, 2011, in the amount of $15,000.00. Review of bank statements revealed the following totals of the resident trust accounts: March 3, 2011=$16,642.51; March 8, 2011=$16,612.99; March 9, 2011=$16,595.21; April 1, 2011=$18,583.26; March 5, 2011=$19,274.73; May 3, 2011=$20,759.95; and May 5, 2011=$20,239.46. Interview on May 12, 2011, at 11:35 a.m., with the Administrator, in the Administrator's office, confirmed the surety bond was not sufficient to ensure the resident trust accounts.	F 161	161 This facility does purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. All residents having funds in the resident trust account have the potential to be affected. The surety bond was increased to $30,000.00 by 6/3/11 by the Administrator. Audits will occur five times per week times four weeks then weekly to ensure compliance by the BOM or her designee. The results of these audits will be reported to the QA Committee quarterly by the Business Office Manager. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	6/3/11
F 164	483.10(e), 483.75(l)(4) PERSONAL	F 164		

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F 164 SS=D	Continued From page 3 PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the confidentiality of the clinical record for one (#13) of twenty-three residents reviewed.	F 164	F164 This facility does ensure that the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. All residents have the potential to be affected. All licensed nursing staff will be in-serviced on 5/25/11 by the DON regarding keeping the clinical records closed when not in use. Daily random monitoring will be done by the DON or her designee. Audits will occur five times per week times four weeks then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the DON. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	6/3/11

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F 164	Continued From page 4 The findings included: Observation on May 10, 2011, at 1:16 p.m., revealed Registered Nurse (RN) #1 in the hallway preparing medications for resident #13. Observation revealed after RN #1 prepared the medications, the Medication Administration Record (MAR) was left on top of the medication cart, with the page uncovered, with the resident's name and medication list in sight of anyone passing by the medication cart. Interview on May 10, 2011, at 1:20 p.m., with RN #1, in the hallway, confirmed the confidentiality of the clinical record was not maintained.	F 164		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post a notice indicating the availability of the most recent State survey results in a place readily accessible to residents. The findings included:	F 167	F167 This facility does make the results available for examination and does post in a place readily accessible to residents and does post a notice of their availability. All residents have the potential to be affected. The binder with the survey results was made readily accessible to residents with a notice of their availability on 5/10/11 by the Maintenance Supervisor. The residents will also be made aware of where the survey results can be located during the resident council meeting on 5/24/11 by the Activity Director. The Administrator or her designee will monitor the accessibility of the survey	6/3/11

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F 167	Continued From page 5 Observation on May 9, 2010, at 10:00 a.m., revealed the results of the most recent State survey were located outside the Administrator's office in a white binder, inside a plastic holder, approximately five feet off the floor, with no signage to indicate the survey results were located inside the white binder. Group interview on May 10, 2011, at 9:00 a.m., with residents (#14, #15, #16, #17, and #18), in the beauty shop, revealed the residents were not aware of where the results of the most recent State survey were located. Interview with resident #11 on May 11, 2011, at 4:45 p.m., in the courtyard, revealed the resident had no knowledge of the location of the posting of the facility's survey results. Observation and interview on May 10, 2011, at 2:40 p.m., with the Administrator, revealed the results of the most recent State survey were located outside the Administrator's office in a white binder, inside a plastic holder, approximately five feet off the floor. Continued observation and interview confirmed there was no signage to indicate the survey results were located inside the white binder, and confirmed the survey results were not accessible to residents requiring a wheelchair for locomotion.	F 167	results by random questioning of residents to ensure compliance. Audits will occur five times per week times four weeks then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the Administrator. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 This facility does promote care for residents in a manner and in an environment that maintains or	6/3/11

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F 241	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure dignity for three (#2, #3, #13) residents of twenty-three residents reviewed. The findings included: Resident #2 was admitted to the facility on April 17, 2009, with diagnoses including Urinary Tract Infection, Mental Disorder, and Chronic Obstructive Pulmonary Disease. Observation on May 10, 2011, at 1:55 p.m., revealed the resident lying on the bed. Further observation revealed the Maintenance Director entered the resident's room without knocking. Interview on May 10, 2011, at 1:55 p.m., with the Maintenance Director, in the hall, confirmed the Maintenance Director failed to knock on the door prior to entering the resident's room. Observation of a medication pass for resident #3 on May 10, 2011, at 8:05 a.m., revealed RN #1 (registered nurse) entered resident #3's room, without knocking on the door. Continued observation revealed resident #3 had three other roommates. Interview with the Director of Nursing on May 12, 2011, at 7:10 a.m., in the administrator's office, confirmed staff are to knock before entering the resident's room.	F 241	enhances each resident's dignity and respect in full recognition of his or her individuality. All residents have the potential to be affected. All facility staff will be in-serviced on dignity and respect of all resident's by the DON on 5/25/11. This will include knocking on doors before entering a room. The DON or her designee will be responsible for monitoring by random observation of staff entering rooms. Audits will occur five times per week times four weeks then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the DON. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	

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F 241	Continued From page 7 Observation on May 10, 2011, at 1:16 p.m., revealed Registered Nurse (RN) #1 entered resident #13's room, to administer medications, without knocking on the door prior to entering the resident's room. Interview on May 10, 2011, at 1:20 p.m., with RN #1, in the hallway, confirmed RN #1 failed to knock or request admittance to the resident's room, prior to entering the room to administer medications.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a clean and sanitary environment in one shower room (400) of two shower rooms observed and failed to maintain a chair for one resident (#22) of twenty-three residents reviewed. The findings included: Observation on May 10, 2011, at 1:45 p.m., of the 400 shower room, revealed a dried brown substance on the commode seat. Interview and observation on May 10, 2011, at 1:45 p.m., with the Director of Nursing, in the 400	F 253	F253 This facility does provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. All residents have the potential to be affected. The commode in the 400 hall shower room was cleaned on 5/10/11 by housekeeping staff. The gerichair arms for resident #22 was repaired on 5/11/11. All nursing home housekeeping staff will be in-serviced by 6/3/11 regarding proper cleaning of bathrooms by the housekeeping supervisor. Maintenance will be in-serviced by 6/3/11 by the administrator regarding proper upkeep of gerichairs. The Administrator or her designee will be responsible for monitoring by	6/3/11

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F 253	Continued From page 8 shower room, confirmed a dried brown substance on the commode seat. Observation on May 10, 2011, at 8:25 a.m., of resident #22's room, revealed the resident was sitting in a gerichair. Continued observation revealed both arms of the chair were torn, the material of the chair was cracked and unraveled. Interview with CNA #3 (certified nursing assistant) on May 10, 2011, at 8:35 a.m., in the hallway, confirmed the chair was in need of repair.	F 253	random observation of patient care areas regarding cleanliness of the facility and also equipment upkeep. Audits will occur five times per week times four weeks then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the DON. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Business Office Manager and others as indicated.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 This facility does ensure that a comprehensive care plan is developed within 7 days after the completion of the comprehensive assessment. All residents have the potential to be affected. The care plans for residents #10 and #12 were updated on 5/17/11 by the MDS Coordinator. Care plans will be reviewed and updated during morning meeting 5 times per week during morning meeting by the IDT. Functionality of alarms will be monitored by licensed staff every shift. All licensed nursing staff will be in-serviced on this on 5/25/11 by the DON. All nursing home staff will be in-	6/3/11

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F 280	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the Care Plan for two (#10, #12) residents of twenty-three residents reviewed. The findings included: Resident #10 was admitted to the facility on April 4, 2011, with diagnoses including Acute CVA (Cerebral Vascular Accident) with Right Side Hemiparesis. Medical record review of a fall risk assessment dated April 5, 2011, revealed the resident was at high risk for falls. Review of a facility investigation dated April 24, 2011, revealed "...Resident putting self back to bed (after) putting self on bedside commode (without) assist. Resident fell down to...knees...If the resident has a body/bed alarm, was it in place? Yes...Was alarm sounding? No..." (no injury) Medical record review of the Care Plan dated April 21, 2011, revealed no documentation of the bed alarm. Observation on May 12, 2011, at 7:00 a.m., revealed the resident in the dining area, seated in a wheelchair with a clip alarm attached to the resident's shirt. Observation on May 12, 2011, at 7:00 a.m., of the resident's room, revealed a pressure pad alarm on the resident's bed.	F 280	serviced on 5/25/11 by the DON regarding not leaving resident #12 unattended until transfer is complete when the resident has requested to be put in bed. Audits will occur 5 times per week by the DON or her designee to ensure compliance with care plan updates and alarm functionality. Random observation will be done regarding resident #12 to ensure compliance. Audits will occur five times per week times four week and then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 280	Continued From page 10 Interview on May 12, 2011, at 7:25 a.m., with the DON (Director of Nursing), in the DON's office, confirmed the Care Plan had not been revised to include the bed alarm. Resident #12 was admitted to the facility on February 18, 2011, with diagnoses including Contusion of the Knee, Bipolar Disorder, and history of Cerebrovascular Accident with Left Sided Hemiparesis. Medical record review of the nursing notes and facility documentation dated February 25, 2011, and April 4, 2011, revealed the resident experienced falls after requesting assistance with transfers and being told additional help for the transfers was being sought. Continued review of the nursing notes and facility documentation dated February 25, 2011, and April 4, 2011, revealed the resident was found on the floor while left unattended after requesting assistance with transfers. Medical record review of the Care Plan reviewed on March 8, 2011, revealed no intervention to address the resident's need to be attended if transfers were requested. Interview on May 12, 2011, at 9:35 a.m., with the Assistant Director of Nursing, in the Director of Nursing's office, revealed the resident was impulsive and sometimes made poor decisions, and confirmed the current Care Plan was not revised to include the resident's need to be attended when transfer assistance was requested.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 11 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one (#1) of twenty-three resident's reviewed. The findings included: Resident #1 was admitted to the facility on August 17, 2007, and readmitted on April 11, 2011, with diagnoses including Pneumonia, Failure to Thrive, Fractured Tibia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Osteoporosis, Generalized Anxiety, and Depressive Disorder. Medical record review of the physician's recapitulation orders dated May 2011, revealed the resident was to receive a magic cup (nutritional supplement with additional calories) with meals, three times a day. Observation on May 10, 2011, at 8:16 a.m., revealed Certified Nursing Assistant (CNA) assisting the resident with the breakfast meal. Continued observation revealed there was no magic cup on the resident's breakfast tray. Observation on May 11, 2011, at 7:10 a.m., revealed a CNA assisting the resident with the breakfast meal, and there was no magic cup on the resident's breakfast tray.	F 281	F281 This facility does ensure that the services provided or arranged by the facility meet professional standards of quality. All residents have the potential to be affected. Written communication was sent to dietary on 5/11/11 by nursing staff regarding resident #1. The tray card for resident # 1 was corrected as of 5/11/11 by the Dietary Manager ensuring that the appropriate items are sent each meal. All Dietary staff will be in-serviced by 5/25/11 regarding ensuring all residents receive the correct items on their tray. Audits will occur 5 times per week by the Dietary Manager or his designee ongoing to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director , Dietary Manger and others as indicated.	6/3/11

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F 281	Continued From page 12 Observation and interview on May 11, 2011, at 7:20 a.m., with the Director of Nursing, in the resident's room, confirmed there was no magic cup provided with the breakfast meal, and confirmed the physician's orders were not followed.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to establish an individualized toileting plan for one (#10) of twenty-three residents reviewed. The findings included: Resident #10 was admitted to the facility on April 4, 2011, with diagnoses including Acute CVA (Cerebral Vascular Accident) with Right Side Hemiparesis. Medical record review of the Minimum Data Set dated April 11, 2011, revealed the resident was	F 315	F315 This facility does ensure that when a resident enters the facility without an indwelling catheter, the resident is not catheterized unless his/her clinical condition demonstrates that catheterization was necessary. Also, a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident # 10 was placed on the Bowel & Bladder program on 5/12/11. The MDS Coordinator, Restorative Nurse and Tech were in-serviced by the DON on 5/24/11 regarding proper communication in relation to the bowel & bladder program. All direct care staff were in-serviced on 5/25/11 by the Director of Nursing regarding the policy and procedures for proper monitoring for the bowel & bladder program. Monitoring will occur five times per	6/3/11

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F 315	Continued From page 13 frequently incontinent of bladder. Medical record review of the Bowel and Bladder Training Assessment dated April 12, 2011, revealed the resident was a candidate for toileting (timed voiding). Review of facility policy, Types of Bowel and Bladder Restorative Programs revealed "...Maintenance Program These residents either lack the cognitive ability to independently perform elimination functions or lack the physical control...There will be some residents who have a low probability of responding and the objective is to determine their voiding pattern...and assure the staff assist or remind them to void prior to expected episodes of incontinence..." Observation on May 12, 2011, at 7:00 a.m., revealed the resident seated in a wheelchair in the dining area. Interview on May 12, 2011, at 10:05 a.m., with the Assistant Director of Nursing, in the Director of Nursing office, confirmed an individualized toileting plan had not been established for the resident.	F 315	week times four weeks then weekly times four weeks, and then random to ensure compliance by the DON or her designee. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 This facility does ensure that ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All residents have the potential to be affected.	6/3/11

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, observation, and interview, the facility failed to ensure adequate supervision while toileting for one resident (#1), failed to ensure adequate supervison for one resident (#4), failed to ensure safety device was functioning for one resident (#10) of twenty-three residents reviewed, and failed to ensure a safe enviornment for one shower room of two shower rooms observed. The facility's failure caused actual harm to resident #1. The findings included: Resident #1 was admitted to the facility on August 17, 2007, and readmitted on April 11, 2011, with diagnoses including Pneumonia, Failure to Thrive, Fractured Tibia, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Osteoporosis, Generalized Anxiety, and Depressive Disorder. Medical record review of the Minimum Data Set dated December 16, 2010, revealed the following: a score of ten on the Brief Interview for Mental Status (BIMS) indicating the resident had moderately impaired cognitive skills; was totally dependent for transfers, toilet use, and personal hygiene; did not walk; was not steady and only able to stabilize with human assistance moving from seated to standing position; and was not steady and only able to stabilize with human assistance moving on and off the toilet. Medical record review of the Assessment of Risk	F 323	Resident #1's incident was reviewed on 1/25/11 by the IDT. Staff were educated regarding proper positioning of wheelchair cushions on 4/28/11 by the therapy department. Resident # 1's incident was reviewed on 3/7/11 and a soft lap belt or lap buddy was to be used when resident was up in wheelchair or a gait belt to be used when on BSC of shower chair. Resident #4 was assessed by 5/19/11 by the DON with no adverse reaction to incidents. Staff will be in-serviced on 5/25/11 regarding the proper use of the lift when transferring this resident. Resident # 10 was assessed on 5/19/11 by the DON with no adverse reaction noted. All licensed nursing staff will be in-serviced on 5/25/11 by the DON regarding the monitoring of alarms functionality every shift. All incidents will be reviewed in morning meeting five times per week with the IDT. This will include interventions and care plan updates. Monitoring will occur five times per week times four weeks then weekly times four weeks, and then random to ensure compliance by the DON. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA	

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F 323	Continued From page 15 for Falls dated September 22, 2010, revealed the resident was at high risk for falls. Medical record review of the Care Plan reviewed on December 28, 2010, revealed "...potential for falls r/t (related to)...confusion, impaired sense of balance...hx (history) of falls, weakness...observe resident for signs of fatigue when sitting in chair..." Medical record review of the nursing notes dated January 24, 2011, at 9:00 a.m., revealed "In W/C (wheelchair) being taken to BRoom (bathroom) in W/C waiting for transfer, cushion in seat was over edge of seat, resident slipped out of chair to floor, small abrasion on (L) (left) shoulder, cleaned et (and) dressed..." Medical record review of a nursing note written on a Condition Change Form, dated March 5, 2011, no time noted, revealed "CNA (Certified Nursing Assistant) had resident on BSC (bedside commode)...was standing at the sink brushing...teeth (dentures), heard noise, resident had slid off BSC to floor on...face. Had cut on R (right) & forehead, bruised shoulder and nose bleeding-Lifted to gurney & transferred to ER (emergency room)." Medical record review of the hospital emergency record dated March 5, 2011, revealed the resident had a laceration over the left eyebrow and under the left eyebrow and the resident had received sutures to the laceration. Medical record review of a nursing note dated March 6, 2011, at 1:00 a.m., revealed "Resident returned to room from hospital. Transferred to	F 323	Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 323	Continued From page 16 own bed without awakening. Cut to (L) (left) cheek and stitches over left eye..." Medical record review of a nursing note dated March 6, 2011, at 12:10 p.m., revealed "...stitches (upper) (L) eye intact, noted a lot of bruising to eyes and area around. Noted cut to left cheek..." Observation on May 9, 2011, at 1:40 p.m., revealed the resident seated in a recliner beside the bed. Interview on May 10, 2011, at 3:25 p.m., with the Director of Nursing, in the Director of Nursing's office, revealed the resident required line of sight observation when on the commode. Interview on May 11, 2011, at 2:45 p.m, with Certified Nursing Assistant (CNA) #3, in the Director of Nursing's office, revealed on January 24, 2011, CNA #3 had placed the resident in the bathroom, in a wheelchair, with a cushion under the resident's buttocks, and locked the brakes on the wheelchair. Continued interview revealed CNA #3 left the resident in the bathroom and went to the doorway to obtain the assistance of another staff member to transfer the resident from the wheelchair onto the commode. Continued interview with CNA #3 revealed while at the doorway, to request assistance, the resident had unlocked the wheelchair brakes and the cushion under the resident's buttocks slid and the resident had fallen onto the floor. Continued interview with CNA #3 confirmed the resident was unattended at the time of the fall on January 24, 2011. Interview on May 11, 2011, at 3:00 p.m., with	F 323		

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F 323	Continued From page 17 CNA #4, in the Administrator's office, with the Administrator present, revealed on March 5, 2011, CNA #4 had placed the resident on the bedside commode. Continued interview revealed while the resident was seated on the bedside commode, CNA #4 had turned away from the resident, and was washing the resident's dentures at the sink at the time of the fall. Continued interview revealed CNA #4 was aware the resident was sometimes dizzy and unsteady. Continued interview confirmed CNA #4 could not see the resident at the time of the fall. Resident #4 was admitted to the facility on November 9, 2005, and readmitted to the facility on July 9, 2010, with diagnoses including Congestive Heart Failure, Lymphedema Bilateral Lower Extremities, and Diabetes. Medical record review of the MDS (Minimum Data Set) dated October 25, 2010, revealed the resident required extensive assistance with two plus persons physical assist for transfers. Medical record review of the MDS dated January 17, 2011, revealed the resident required extensive assistance with two plus persons physical assist for transfers. Medical record review of the fall risk assessment dated December 26, 2010, revealed the resident was at high risk for falls. Review of the facility investigation dated December 26, 2010, revealed, "...CNA (certified nursing assistant) was putting resident to bed and resident was holding to bedrail panicky, said rail	F 323		

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F 323	Continued From page 18 was coming off, CNA held (resident) (and) let (resident) to floor...staff educated to ensure adq (adequate) help to support/transfer resident (related to) obesity, (decreased) strength (and) unsteady gait (with) amb (ambulation)/transfer... (no injury)." Review of the facility investigation dated February 10, 2011, revealed, "...CNA was putting resident to bed, resident started going down CNA slid (resident) to floor...Staff educated either to use lift or 2 person transfer for any transfer...(no injury)." Review of the facility investigation dated March 15, 2011, revealed "...tech attempted to transfer resident from bed to w/c (wheelchair) (without) assist (and) did not use lift. (Patient) fell in front of w/c...Staff advised by DON (Director of Nursing) that lift is to be used (at) all times when transferring this resident...(no injury)." Interview on May 10, 2011, at 9:45 a.m., with the DON, in the DON's office, confirmed two person assistance or the lift was not used at the time of the falls on December 26, 2010, February 10, 2011, and March 15, 2011. Resident #10 was admitted to the facility on April 4, 2011, with diagnoses including Acute CVA (Cerebral Vascular Accident) with Right Side Hemiparesis. Medical record review of the Minimum Data Set dated April 11, 2011, revealed the resident required extensive assistance with two plus persons physical assist for transfers.	F 323		

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F 323	Continued From page 19 Medical record review of the fall risk assessment dated April 5, 2011, revealed the resident was at high risk for falls. Review of the facility investigation dated April 24, 2011, revealed, "...Resident putting self back to bed (after) putting self on bedside commode (without) assist. Resident fell down to...knees...If the resident has a body/bed alarm, was it in place? Yes...Was alarm sounding? No..." (no injury) Interview on May 12, 2011, at 7:25 a.m., with the DON (Director of Nursing), in the DON's office, confirmed the safety device was not functioning at the time of the fall on April 24, 2011. Observation on May 10, 2011, at 1:45 p.m., of the 400 shower room, with the Maintenance Director, revealed a screw missing at the bottom of a corner strip of metal flashing. Further observation revealed the metal flashing protruding out at the bottom approximately ½ inch. Interview on May 10, 2011, at 1:45 p.m., with the Maintenance Director, in the 400 shower room, confirmed the screw was missing and the metal flashing was protruding at the bottom.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356	F356 This facility does post the following information on a daily basis: Facility Name The current Date	6/3/11

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F 356	Continued From page 20 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post the nurse staffing data. The findings included: Observation on May 9, 2011, at 10:00 a.m., revealed there was no nurse staffing data posted in a prominent place readily accessible to residents and visitors.	F 356	The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RN LPN CNT Resident Census All residents have the potential to be affected. The facility staffing information was posted on 5/9/11 by the DON. In-service was given by the Administrator to the DON and Assistant DON on 6/1/11 regarding the posting of the staffing information on a daily basis. Monitoring will occur five times per week times to ensure compliance by the Administrator or her designee. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of the Administrator, DON, Assistant	

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F 356	Continued From page 21 Observation and interview on May 9, 2011, at 10:30 a.m., with the Director of Nursing, outside the Administrator's office; confirmed the nurse staffing data was not posted.	F 356	DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview with six residents (#14, #15, #16, #17, #18, and #11) the facility failed to offer daily bedtime snacks. The findings included: Group interview on May 10, 2011, at 9:00 a.m., with residents (#14, #15, #16, #17, and #18), in the beauty shop, revealed bedtime snacks were not offered every night.	F 368	F368 This facility does ensure each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. The facility must offer snacks at bedtime daily. All residents have the potential to be affected. A new hydration sheet that includes the offering of bedtime snacks was implemented on 5/11/11 by the DON. Nurses were in-serviced at that time by the Assistant DON. All nursing staff will be in-serviced on 5/25/11 regarding the offering of bedtime snacks and documentation of this by the DON. Monitoring will occur five times per week times to ensure compliance by the DON or her designee. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of	6/3/11

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PRINTED: 05/16/2011
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED REGIONAL MEDICAL CENTER NURSING HOME	1001 MCARTHUR DRIVE MANCHESTER, TN 37355

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F 368	Continued From page 22 Interview on May 11, 2011, at 4:45 p.m., with resident #11, in the courtyard revealed the resident was not offered a bedtime snack every night. Interview on May 10, 2011, at 4:50 p.m., with Licensed Practical Nurse (LPN) #3, revealed the diabetic residents received a bedtime snack nightly. Continued interview with LPN #3 revealed LPN #3 instructed the Certified Nursing Assistants to offer snacks to residents who were not eating well. Continued interview confirmed bedtime snacks were not offered to all residents nightly.	F 368	the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary environment and failed to maintain proper temperatures. The findings included: Observation on May 9, 2011, at 10:15 a.m., with	F 371	F371 This facility does procure food from sources approved or considered satisfactory by Federal, State or local authorities; and also store, prepare, distribute and serve food under sanitary conditions. All residents have the potential to be affected. 1. The thermometer in the walk in freezer was replaced by the Dietary Manager on 5/9/11. 2. Peaches were discarded by the Dietary Manager on 5/9/11. 3. The walk in cooler was repaired by the Maintenance Department on 5/11/11. The milk was properly stored in the cooler by the Dietary Manager on 5/9/11. 4. The reach in cooler was checked /repaired by the maintenance	6/3/11

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F 371	Continued From page 23 the Certified Dietary Manager (CDM) present, in the dietary department revealed the following: 1. The walk in freezer revealed no thermometer to verify the temperature. 2. The walk in refrigerator had an institutional size can of peaches open and dated May 6, 2011, (stored in an aluminum can). 3. The walk in cooler temperature was 42 degrees F. (Fahrenheit), and the extra milk was stored in a crate on the floor. 4. The reach in cooler temperature was 44 degrees F., hamburger buns were stored in plastic wrap and dated April 16, 2011, (the CDM disposed of the hamburger buns.), and shredded cheese in a five pound bag with ¾ remaining had been opened and not dated. 5. A sanitizing bucket with solution was stored next to the cooking oil. 6. The meat slicer had debris of white type of meat on the entire blade. 7. Dietary staff #1 had full beard with no protection (no cover for the beard). 8. The air vents for the ice machine had dust accumulation present. 9. The full size pans stacked, one out of 9 had dried debris, ½ size pans one of 6 had dried debris. Interview with the CDM on May 9, 2011,	F 371	department on 5/19/11. The hamburger buns were discarded by the Dietary Manager on 5/9/11. The bag of shredded cheese was properly labeled by the Dietary Manager on 5/9/11. 5. The sanitizer bucket was removed by the Dietary Manager on 5/9/11. 6. The meat slicer was cleaned by the Dietary Manager on 5/9/11. 7. The dietary staff were in-serviced on 5/11/11 by the Dietary Manager regarding either shaving facial hair or wearing a beard cover. 8. The air vents on the ice machine were cleaned by dietary staff on 5/9/11. 9. The stacked pans were immediately removed and properly cleaned by the Dietary Manager on 5/9/11. 10. Scales were received on 5/9/11 and put into use by the Dietary Manager. 11. The milk was removed from the test tray and discarded by the Dietary Manager on 5/11/11. All Dietary staff was in-serviced by 5/19/11 regarding all issues noted above by the Dietary Manager. The Dietary Manager or his designee will monitor the corrective action to ensure effectiveness of these actions by making random checks. These random checks will occur five times per week times 4 weeks. If no further issues are identified, random checks will occur at least weekly to ensure compliance. The results of these checks will be reported to the QA Committee quarterly.	

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F 371	Continued From page 24 beginning at 10:15 a.m., in the dietary department, confirmed no thermometer in the walk in freezer, peaches stored in can were out of date, the walk in cooler temperature of 42 degrees F, the extra milk was stored on the floor, the hamburger buns were to be thrown out, the shredded cheese had no date, a sanitizing bucket was stored next to the cooking oil, the meat slicer was unclean, and Dietary staff #1 had no protection on beard, and the air vents on the ice machine had dust accumulation, and the stacked pans had dried debris. Observation of the meal lunch tray line on May 9, 2011, at 11:40 a.m., with the CDM, revealed Dietary staff #1 working the tray line with beard unprotected, and Dietary staff #2 working in the dietary department with beard unprotected. Interview with CDM at the time of the observation confirmed the staff had no protection on the beards. Review of the facility's menus revealed "turkey w/ (with) cran glaze 3 ounces." Observation of the lunch meal tray line on May 9, 2011, at 11:40 a.m., with the CDM revealed thin sliced turkey being served. Interview with the CDM at the time of observation revealed the facility had no scale to measure the turkey being served. Interview with resident #14 on May 10, 2011, at 9:00 a.m., in the beauty shop, revealed the resident stated the "turkey wasn't enough to feed a little dog."	F 371	The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Dietary Manager and others as indicated.	

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F 371	Continued From page 25 Observation of the breakfast tray line on May 11, 2011, at 7:00 a.m., in the dietary department, revealed dietary staff #1 serving on the tray line with beard unprotected. Observation of a breakfast test tray on May 11, 2011, at 7:40 a.m., with the CDM, in the day room, revealed a carton of milk with a temperature of 47 degrees F. The CDM confirmed the temperature at the time of observation.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F441 This facility has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. All residents have the potential to be affected. All nursing staff will be in-serviced on 5/25/11 by the Director of Nursing regarding peri-care policies and procedures. The soap dispenser was changed out on 5/10/11 by the Maintenance Director. The housekeeping supervisor and maintenance director are working to replace all soap dispensers. The housekeeping staff will be in-serviced	6/3/11

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F 441	Continued From page 26 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to maintain infection control for one resident (#9) for perineal care; failed to provide soap in bathroom for one resident (#23); failed to use gloves to give injection for one resident (#19) of twenty-three residents reviewed; failed to process clothing in a sanitary manner and maintain the laundry department in a sanitary manner. The findings included: Resident #9 was admitted to the facility on March 29, 2011, with diagnoses including Anxiety Disorder, Depression, and Muscle Weakness. Medical record review of the Minimum Data Set dated April 22, 2011, revealed the resident was incontinent of bowel and bladder. Observation on May 10, 2011, at 9:40 a.m., in the resident's room, revealed CNA #1 and CNA #2	F 441	by 6/3/11 regarding ensuring all soap dispensers have soap in them. Resident # 19 was assessed with no adverse reactions from receiving an injection without the nurse wearing gloves. All licensed nursing staff will be in-serviced on 5/25/11 by the DON regarding needle stick protocol. The laundry worker was in-serviced on 5/11/11 by the housekeeping supervisor regarding policies and procedures. The laundry was rewashed 5/11/11 by the laundry worker. Skills competency will be completed on all licensed nurses by 6/3/11 by the Director of Nursing or her designee in relation to hand washing and needle stick protocol. Skills competency will be completed on all techs regarding peri-care by 6/3/11. Monitoring will occur five times per week times four weeks then weekly times four weeks, and then random to ensure compliance by the DON or her designee. The results of these checks will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets	

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F 441	Continued From page 27 (certified nursing assistant) providing incontinence care to the resident. Continued observation revealed both CNAs wore gloves to provide the care, using the same gloves CNA #1 adjusted the controls for the bed, both CNAs removed the resident's gown and placed clean gown on the resident; CNA #2 adjusted the bed side rail, and both CNAs adjusted the resident's blanket. Continued observation revealed CNA #2 removed gloves without washing hands, placed the resident's supplies in the closet, left the room, retrieved a wash cloth from the linen cart, returned to the room, and proceeded to wash the resident's face. Review of the facility's policy "Standard Precautions/Infection Control" revealed "...handwashing...1. Before direct contact with patients...6. after removing gloves." Interview with CNA #1 and CNA #2 on May 10, 2011, at 9:40 a.m., in the hallway, confirmed the CNAs had not removed gloves or disinfected hands after providing incontinent care to the resident and had not washed hands prior to washing the resident's face. Observation of a medication pass on May 10, 2011, at 8:25 a.m, in resident #23's room, revealed LPN #1 (licesened practical nurse) went to the bathroom to wash hands. LPN #1 came out and stated there was no soap available in the bathroom and went to retrieve soap to wash hands before finishing the medication pass. Interview with LPN #1 on May 10, 2011, at 8:40 a.m., in the hallway, confirmed there was no soap available to wash hands in the resident's	F 441	quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 441	Continued From page 28 bathroom. Observation on May 10, 2011, at 6:55 a.m., revealed Licensed Practical Nurse (LPN) #2, administering medications to resident #19. Continued observation revealed LPN #2 administered an injection of insulin to the resident without applying gloves. Review of the facility's policy Infection Control/Needlestick Protocol revealed "...During the administration of any injection nursing personnel are to wear gloves as an added protection for the employee and the resident..." Interview on May 10, 2011, at 6:58 a.m., with LPN #2, in the hallway, confirmed gloves were not applied when the insulin injection was administered. Observation on May 11, 2011, at 9:30 a.m., in the laundry room, with the Housekeeping Manager, revealed two baskets of dirty clothes sitting on the floor and one basket of clean clothes sitting on the floor, approximately four feet apart, and eight dirty buffing pads sitting on top of a housekeeping cart. Continued observation revealed laundry worker #1 removed clean clothes from the washer and placed in a basket with a clean sock falling on the floor. Continued observation revealed laundry worker #1 picked the sock up from the floor and placed the sock on top of the clean clothes in the basket.	F 441		

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F 441	Continued From page 29 Review of facility policy, Laundry Procedures and Policies revealed, "...When the soiled laundry arrives in the laundry room it is to be kept opposite of the clean laundry...If at any time clean laundry comes in contact with the floor...the item is to be returned to its personal hamper to be washed again as soon as possible...Soiled laundry and clean laundry are to never come in contact with each other: they are to be kept at the furthest distance possible from each other when laundry duties are being performed..." Review of facility policy, Buffer Pads Cleaning Procedure and Policy, revealed, "...Cleaning should occur as soon as the pad is taken off the buffer. After the pad has been cleaned and has had time to dry, the pads are to be bagged up double layer in plastic bags and stored..." Interview on May 11, 2011, at 9:30 a.m., with laundry worker #1, in the laundry room, revealed "...sometimes may have dirty clothes in dirty clothes hamper in the laundry room while clean clothes are in the process of being washed and hung up." Interview on May 11, 2011, at 9:45 a.m., with the Housekeeping Manager, in the laundry room, confirmed the sock had been dropped on the floor and then placed on the clean clothes and the buffing pad were dirty.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	F514 This facility maintains clinical records on each resident in accordance with accepted	6/3/11

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F 514	Continued From page 30 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure complete documentation in the medical record for one (#4) resident of twenty-three residents reviewed. The findings included: Resident #4 was admitted to the facility on November 9, 2005, and readmitted to the facility on July 9, 2010, with diagnoses including Congestive Heart Failure, Lymphedema Bilateral Lower Extremities, and Diabetes. Medical record review of a physician's order dated April 19, 2011, revealed "...Strict I (and) O (Intake and output)..." Medical record review of the I and O record dated April 21, 2011, revealed no output documented on the 7-3 shift. Medical record review of the I and O record dated April 26, 2011, revealed no output documented on the 7-3 shift. Medical record review of the I and O record dated April 28, 2011, revealed no output documented on the 3-11 shift.	F 514	professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. Resident # 4 was assessed on 5/20/11 by the Director of Nursing and suffered no adverse affect related to the missing documentation. All licensed nursing staff will be in-serviced on 5/25/11 regarding intake & output. All residents on I & O have the potential to be affected. The DON or her designee will monitor I & O sheets five times per week then weekly times four weeks, and then random to ensure compliance. The results of these checks will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 514	Continued From page 31 Interview on May 10, 2011, at 1:10 p.m., with the DON (Director of Nursing) in the DON's office, confirmed no documentation of the output on April 21, 2011 and April 26, 2011, 7-3 shift and on April 28, 2011, 3-11 shift.	F 514		